Senate Republican Office of Policy

Briefing Report

Workers' Compensation—Comprehensive Reform Needed, not a Band-Aid

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Workers' Compensation costs are skyrocketing. By 2003 California's businesses are expected to pay $20 billion in workers' compensation premiums. California employees receive benefits that are among the lowest in the nation. While California employers are paying the highest premiums. Employers are faced with difficult choices such as laying off employees, eliminating other benefits, cutting wages and salaries or leaving California altogether. The response of the Governor and the legislative Democrats was to pass AB 749, which raised benefits, without necessary reforms to insure the system can survive. Legislative Republicans have urged the Governor to call a Special Session to address the crisis. Experts rate California's system the most cumbersome and litigious in the nation. Without systematic reforms, California's business environment will continue to falter. Without a robust business economy, California's budget woes will never end.

Executive Summary

Workers' compensation insurance covers employees for injuries that occur at work. Originally designed as a non-adversarial "no-fault" insurance system, it has become increasingly adversarial over the years. In the 1980s, the cost of workers' compensation insurance was on the rise, creating a problem for business. In response minor reforms were enacted in 1989 and 1991. Significant workers' compensation reforms were enacted in 1993. Ironically, the situation then—one of the most expensive systems in the country with relatively low benefits to injured workers—mirrors today's situation.

In 2002, after three years of grueling negotiations, fierce intra-party bickering among Democrats, and the threat of a ballot measure, legislative Democrats and the Governor struck a deal to significantly boost benefits for injured workers. AB 749 promised increased weekly benefits for injured workers along with claims of new cost-cutting reforms to minimize the impact on California businesses. The costs of the reforms to the system were significantly underestimated while the cost savings were wildly overestimated. In addition many of the "reforms" failed to seriously address fraud, over-

utilization by medical providers, and the endless litigation surrounding the claims process.

To achieve real reform—not a Band-Aid—Senate Republicans support a comprehensive legislative solution to address the inadequacies in the system, based on specific principles.

♦ Republican Principles

Any reform measures supported by Republicans should reflect the following principles:

- ***Adequate Coverage.*** The benefit system must provide adequate coverage to seriously injured workers. The current system tends to provide excessive benefits to those with little or no serious or permanent injury. In fact 80 percent of the litigation costs are associated with those that have less than 25 percent partial disability.

- ***Medical Cost Controls***. Over-utilization is one of the largest contributors to today's crisis. Cost controls are needed on those medical providers that over-utilize heath care procedures, particularly when the provider's utilization rates are far above national averages.

- ***Adequate Rates.*** Insurance rates should be adequate to cover the cost of providing the coverage. Mandated benefit increases such as those contained in AB 749 were not supportable because it did not contain significant offsetting cost-controlling reforms.

- ***Open Market Competition.*** Rates should continue to be established through open market competition.

- ***Reduce Litigation***. California's workers' comp system was originally predicated on a non-adversarial system, the best approach to provide quick compensation to injured workers. Unproductive and contentious litigation needs to be limited in the workers' compensation system.

- ***Eliminate Fraud.*** Fraud in the workers' compensation system takes many forms. In many ways, it is similar to the fraud found in the Medi-Cal system. In fact, many of the fraudulent providers abusing the system are active in both systems. Any meaningful reform must empower prosecutors, employers and insurers to aggressively end fraud.

Workers' Compensation System Overview

Workers' compensation insurance covers employees for injuries that occur at work. It was originally designed as a non-adversarial "no-fault" insurance system. Over the years, it has become increasingly adversarial. The main interest groups involved in this

issue are business/employers, labor unions, insurers, health care providers, and lawyers. Simply put, the attorneys, health care providers, and labor unions are concerned about benefits, the business interests are concerned about costs, and the insurers are worried about profitability.

There are five basic types of workers' compensation benefits:

- Medical care
- Temporary disability benefits
- Permanent disability benefits
- Vocational rehabilitation services
- Death benefits

Temporary disability benefits are intended to replace 2/3 of the injured worker's income, up to a maximum weekly benefit. Beginning 1/1/03[1], the maximum for temporary disability benefits is $602 per week, increasing in steps to $840 per week on 1/1/05. Adjustments by formula are scheduled to be made in the following years for injuries occurring 1/1/06 and thereafter.

Maximum permanent disability benefits are $230 per week as of 1/1/03 for those claiming 70 percent or less permanent disability, and $270 per week by 1/1/06 for those claiming 70 percent or more. The assessment of the injured worker's permanent impairment and limitations is made by either the treating physician or a "Qualified Medical Evaluator" (QME). The treating physician's presumption, once thought to be a cost-saving reform to end the expensive "dueling doctors" system, was repealed with the passage of AB 749. The presumption is now considered to have been a major reason for cost inflation in the providing of medical care in the past decade.

♦ 1993 Reforms

In the 1980s, the cost of workers' compensation insurance became a huge problem for businesses. Despite the generally improving economy during that decade, the compensation costs increased so rapidly that by the end of the decade the pressure for legislative reform was overwhelming. Modest reforms were enacted in 1989 and 1991.

Then in 1993, the Legislature approved significant workers' compensation reforms. The Legislature was trying to address a fundamental inconsistency in California's workers' compensation system: it was one of the most expensive systems in the nation, yet delivered relatively low benefits to disabled workers. Ironically 10 years later we are in the same situation.

The reforms were extensive. The analysis of just one of the several bills, AB 110 (Peace), is 23 pages long. The bottom line is that these reforms resulted in a

[1] Rates increased on AB 749.

significant reduction in workers' compensation costs and the pressure for additional changes disappeared until 2000 due to a robust economy and premiums that actually dropped significantly.

One of the key changes in 1993 that led to lower premiums was the passage of SB 30 (Johnston) which eliminated the "minimum rate law." Prior to the passage of SB 30, the state established a minimum rate below which insurers could not sell their insurance. This law was intended to protect the solvency of the workers' compensation insurers. Opponents of the law felt that it kept rates artificially high.

SB 30 was passed by Democrats over some Republican opposition, although it was ultimately signed by Governor Pete Wilson. Republicans opposed competitive pricing—which they would traditionally have supported—because workers' compensation insurance was such a money loser at the time that they though it unwise to make such a significant change in the pricing system simultaneously with the other reforms. Since the repeal of the minimum rate law, workers' compensation insurance has seen dramatic price competition. Now, open pricing is the law and there is no serious effort to change it.

At the time of the 1993 reforms, the lawyers and labor unions argued that the reforms should include mandatory benefit increases. The insurers and businesses would be seeing big savings and these savings should, they argued, benefit the workers. In the end, the 1993 reforms included a modest benefit increase.

Since the enactment of the 1993 reforms, insurers and businesses have continued to argue in favor of specific and modest reforms. They also have opposed statutory benefit increases unless those increases are accompanied by additional reforms. Under the open rating system of SB 30, the insurance rates did not result in unusually high profits for compensation insurers. In fact just the opposite occurred.

The aggressive price competition of the past 10 years has many carriers on the financial edge and 25 percent of the carriers have either pulled out of the market or gone insolvent. The State Compensation Insurance Fund, once considered to be the insurer of last resort, saw its book of business rise from 14 percent of the marketplace to nearly 50 percent. On November 2, 1999, the Insurance Commissioner adopted an 18.4 percent increase in the workers' compensation advisory rates, indicating his belief that rates are too low. Since then nearly every quarter has seen advisory rate increases. This created additional pressure in 2000 for the Legislature to mandate a significant benefit increase. The labor unions and the lawyers argued that if insurers are going to increase their rates, the beneficiaries of the coverage should see their benefits increase as well.

♦ The Workers' Comp Ultimatum of 2002: AB 749

With the election of Governor Gray Davis, labor-sponsored workers' compensation benefit increase bills were passed by the Legislature in each of his first three years as

Governor. The Governor vetoed each of those attempts, citing excessive costs to business. Labor groups, backed by Senate President Pro Tem John Burton, promised to place a benefit increase on the ballot if the issue was not resolved, creating a huge political problem for the Governor as he sought re-election.

Finally, after three years of grueling negotiations and fierce intra-party bickering among Democrats, legislative Democrats struck a deal to significantly boost benefits for injured workers. The proposal—brokered amongst the state's top Democrats, labor leaders and attorneys specializing in workers' compensation cases—would bump up weekly benefits for injured workers and purportedly implement new cost-cutting reforms to minimize the impact on California businesses. The employer community—which foots the bill—vehemently opposed AB 749.

One of the more controversial reforms will likely result in an increased reliance on managed health-care organizations to treat injured workers. Though labor leaders and Democrat lawmakers were not thrilled by that provision, Gov. Gray Davis had insisted that burgeoning medical costs be addressed in the legislation.

In a July 2002, the Workers Compensation Insurance Ratings Bureau estimated that AB 749 will increase total annual benefit costs by 17.8 percent, or $3.2 billion, by 2006.

Under AB 749, the maximum weekly benefits for temporarily disabled, and for totally and permanently disabled workers, rose from $490 to $602 on January 1, 2003. By 2005, the maximum jumps to $840 weekly. After that, benefits increase annually, based on a cost-of-living adjustment tied to the state average weekly wage. This will continue to put pressure on premiums for the foreseeable future.

Maximum weekly benefits for most workers with permanent but partial disabilities will increase from $140 to $230 in 2006.

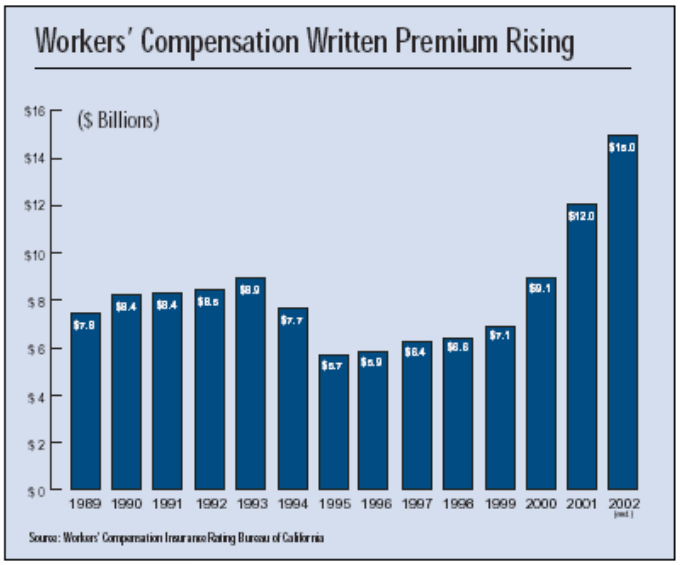
The Current Situation

♦ Dramatic Premium Increases

Employers are receiving drastic premium increases for the fourth year in a row. Workers' compensation insurance premiums have gone up a minimum of 77 percent in the last four years, and employers bear the entire cost. The California Chamber of Commerce attributes the rate increases to 4 factors:

- The passage of AB 749, which increases benefits. Most of those increases will impact businesses this summer.
- An increase in the pure premium advisory rate, that is the advisory rate set by the Department of Insurance. In fact, that rate has increased 50 percent over the last 3 years.
- A surcharge on premiums to cover insolvencies.

- Increased costs to the system, particularly medical benefits.



Courtesy California Chamber of Commerce

On average, insurers charge 17 percent more than the pure premium advisory rate, which is scheduled to increase on July 1. The increases this summer will take into account the benefit increase required by AB 749.

Senate Republicans have proposed putting off the benefit increase in AB 749 until the overall workers' compensation system can be stabilized. This is an important delay, because not only will AB 749 increase premiums, it could increase utilization. The repeal is in SB 1010 (Poochigian).

The root cause of the impending collapse of the system is the financial instability of the workers' compensation insurance industry. In 2000, insurers providing workers' compensation in California paid $1.51 in claims and operating expenses for each $1 taken in as premiums. Even the State Compensation Insurance Fund, considered the insurer of last resort, has threatened to refuse to accept new business. With such tremendous losses, insurance companies are either pulling out of the California market or going out of business.

♦ Workers' Comp Ineffective

California's workers' compensation system earned an "F" for effectiveness in a recent study based on injuries and illnesses recorded on a log required by federal law. The study of all states by the Work Loss Data Institute, an independent database development company focused on workplace health and productivity, looked at data recorded on the OSHA Form 200 to rate the performance of each state's workers' compensation system.

California's "F" was based on data from 2000, the most recent year for which state-by-state data is available. The seven other states and territories receiving "Fs" were New York, Texas, West Virginia, New Jersey, Louisiana, Rhode Island and Puerto Rico. Neighbors Nevada, Arizona and Oregon were among the nine states receiving an "A" for their workers' compensation system performance records, while Washington earned a "C."

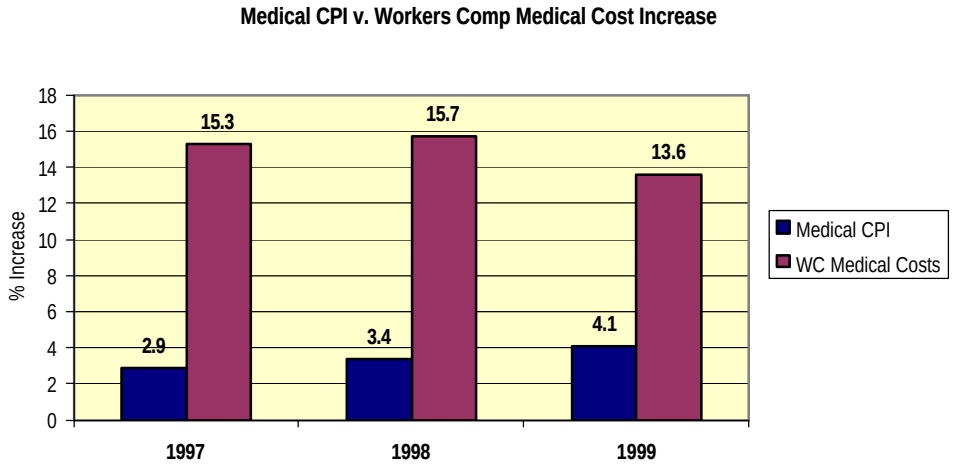
The study looked at six variables: injury and illness incidence rates, cases in which the employee missed work, median disability durations, delayed recovery rate, low back strain and carpal tunnel syndrome.

California ranked among the highest in the nation in median disability durations, an element of cost. When a case requires missed work, the longer the case is out, the higher the indemnity costs. The national average is six days of missed work. California had an average of eight days. Only Puerto Rico (17 days) and Texas (10 days) had higher median disability durations. New York tied with California.

The most common condition listed in workers' compensation claims is low back strain and sprain, which resulted in more than 330,000 cases of lost workdays nationwide in 2000. Although many states had a high incidence of the variety of injuries that go under this category, California was among the four states with the worst outcomes for this condition.

♦ Increased Costs to System

One of the mysteries of California's workers' compensation system is how claim frequency can drop 3.4 percent from 2000, yet claim costs continue to rise along with overall system costs. The ultimate cost of each claim for accident year 2001 was $43,317, up from $39,146 in 2000, according to the Workers' Compensation Insurance Rating Board.



Medical Costs

Medical costs have increased more than 100 percent since 1999—even though the fees for treatment codes have not been increased since 1984. In 1991, the average

medical cost per indemnity claim was $8,935. By 2001, the average cost per claim had skyrocketed to $22,765. Medical inflation within the California workers' compensation system exceeds the national rate of medical cost inflation.

A California Workers' Compensation Institute study found that California's chiropractic costs rose 153 percent from 1996 to 2001, from $77 million to $195 million, while the average number of chiropractic procedures per claim jumped from 59 to 120. As a result, chiropractors are now the leading medical provider in the California Workers' Compensation system. An additional study by the Workers' Compensation Research Institute found that California medical providers, especially chiropractors, treated injured workers more often than their counterparts in other states. SB 228 (Alarcon) and AB 1482 (Richman) both establish medical fee schedules to address high medical costs.

Except for a slight decline in 1996, average payments to chiropractors climbed steadily from $1,455 in 1993 to $2,556 in accident year 1998—a 76 percent increase. The CWCI study also concluded that the average total number of chiropractic visits per claim climbed from 20.2 for accident year 1993 to 29.9 for accident year 1998—a 48 percent increase. Much of the increase was in claims lasting one to two years or less. The average number of claims rose 59 percent for claims in the first year and 70 percent for claims within the first two years. SB 354 (Speier) specifically addresses chiropractic utilization.

Permanent Partial Disability

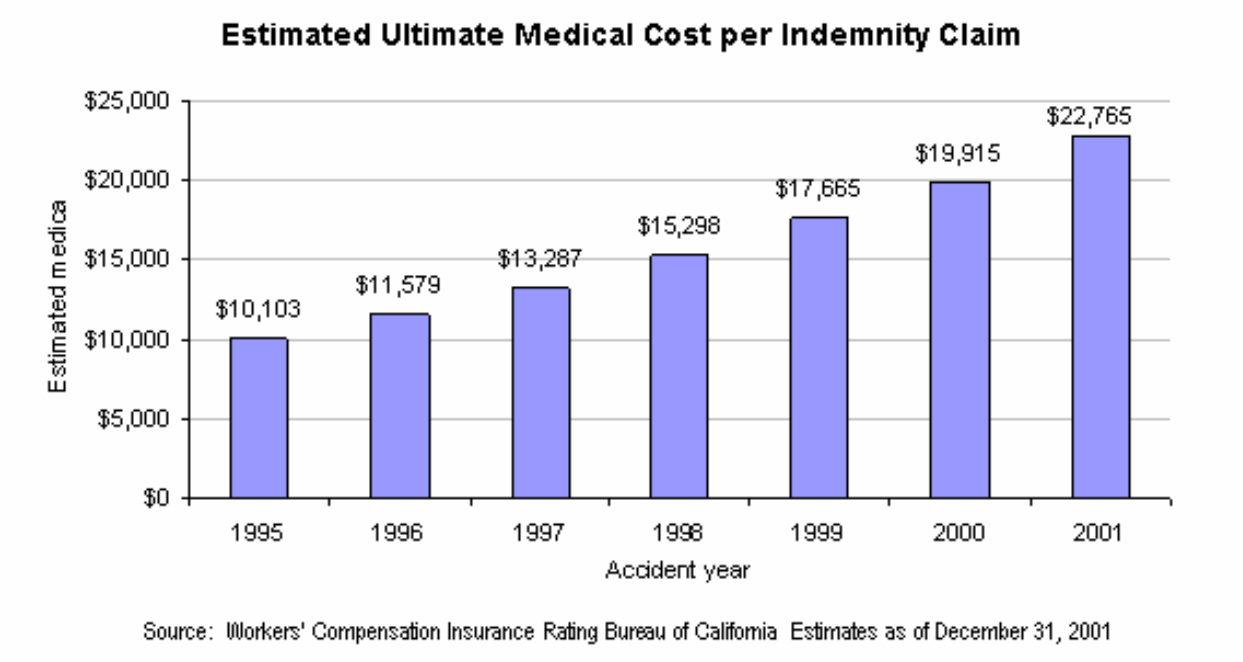
Aside from medical costs, an increase in permanent partial disability (PPD) benefits is affecting costs to the system. The system has seen significant increases in the number of PPD claims for minor disabilities. Ninety percent of all PPD claims are for disabilities of less than 25 percent. Eighty percent of all medical benefit dollars are consumed by these claims and 60 percent of all legal expenses comes from these claims.

Senate Republican Proposals

Fees/Utilization

♦ SB 757 (Poochigian)

Medical costs are climbing. The increased costs are having a significant effect on the premiums paid by employers. Current law does not mandate a medical fee schedule for outpatient services.



SB 757 mandates that the Workers' Compensation Administrative Director develop a "utilization schedule" that provides specific utilization guidelines based on national standards.

Provides that until a fee schedule is developed for outpatient facilities, procedures should be subject to existing fee schedules, regardless of facility.

Mandates that medical providers are to provide only those medical tests, evaluations and treatments necessary to diagnose and treat the work-related injury for which the employee is seeking workers' compensation medical assistance.

♦ SB 899 (Poochigian)—Chamber Sponsored

Current law prohibits physicians from referring workers' comp patients to facilities, including clinical laboratories, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or for diagnostic imaging goods or services, in which they or their families have an ownership interest. This practice is called self-referral. Banning self-referral was estimated to save the workers' compensation system hundreds of millions of dollars per year. However, physicians can self-refer to outpatient surgical centers. This clinical setting is not subject to any cost controls and represents an area subject to over-utilization.

SB 899 will prohibit physicians from referring a patient to an entity in which the physician has a financial interest. This change would remove the incentive for physicians to over-utilize or otherwise improperly benefit financially from the Workers' Compensation system.

♦ SB 223 (Margett)

Existing law requires a pharmacy that provides medicines and medical supplies that are required to cure or relieve effects of an injury covered by workers' compensation to provide the generic drug equivalent, if available, unless the prescribing physician provides otherwise in writing.

SB 223 extends this requirement to hospitals, clinics, and physicians.

Causation/Objective Medical Findings

♦ SB 757 (Poochigian)

Current law does not properly account for an employee's injuries prior to an injury on the job.

SB 757 mandates that the work-related injury must be at least 50 percent of the cause of an injury in order to be compensable.

♦ SB 414 (McClintock)—Chamber-Sponsored

California is the only state that allows employees to receive permanent disability awards based on subjective complaints of pain. For example, a worker with a soft tissue injury to the neck or back who indicates to the doctor that they experience pain when standing, bending, walking, etc., may still receive a substantial monetary award based on the complaint of pain that cannot be confirmed medically. All other states require "objective medical findings" be demonstrated through a medical examination as criteria to receive a monetary award.

SB 414 revises the definition of injury by specifying that the injury or disease arising out of the employment must be one that is certified by a physician using medical evidence based on objective medical findings.

This measure should reduce the number of subjective claims for injury or pain that can not be medically substantiated thus reducing the amount of fraudulent claims.

♦ SB 893 (Morrow)--Chamber Sponsored

Although workers' compensation was designed to be a "no-fault" system, California's system has become very litigious. One of the areas where applicant attorneys prey is that of medical opinions. Subjective standards are being used to determine the extent of an injury, thus creating a "dueling doctors" scenario. This inconsistent and subjective system results in higher attorney fees and lower benefit dollars going to the injured worker. Objective standards from reputable organizations and publications are needed.

SB 893 makes changes designed to shift the law to favor objective opinions and away from a subjective system.

It prohibits the Administrative Director of the Division of Workers' Compensation, when applying the permanent disability schedule, from basing an injury rating on a medical report that is not in accordance with certain medical publications (such as the AMA) relating to injuries and impairments.

It specifies that objective medical findings be used when considering the nature of the injury for purposes of determining the percentages of permanent disability.

♦ SB 366 (Johnson)

Before the revisions to California's workers' compensation stress claim law were made in 1993, California's system was criticized as being too permissive to the point that healthy people with normal everyday stresses were filing stress claims at an enormous cost to employers. In fact, nearly every claim included a stress claim. The lawmakers got the message, and many changes were made.

Prior to 1993, "actual events" of employment needed to be responsible for only 10 percent of the claim. That was increased to 51 percent in 1993, established by a preponderance of the evidence.

But changing the standard for a successful claim to "a preponderance of the evidence" was inadequate and still left the employer liable for damages not entirely the result of the workplace incident or condition.

SB 366 heightens the standard for psychiatric injuries to require clear & convincing evidence and enhance the connection with employment as the cause.

♦ SB 365 (Johnson)

For psychiatric work-related injuries, there must be a finding that the employment is the predominantly cause of the psychiatric injury. That same standard does not apply to all work-related injuries. When an employee with a substantial pre-existing condition suffers "the straw that broke the camel's back" injury on the job, the employer is responsible for the full expense of the condition—even the pre-existing portion that was not work related.

SB 365 changes the general causation standard from an injury that is "proximately caused by employment" to be one where the employment is "the predominant cause of the injury, compared to all other causes combined."

Apportionment Reform

♦ SB 714 (Battin)—Chamber-Sponsored

Apportionment is the process of attributing a certain portion of an injured worker's permanent disability to a previous injury, award or non-work related condition, and assigning the remaining disability to the injury at question. Currently, many physicians give only cursory attention to apportionment to prior injuries or pre-existing illnesses. Employers end up providing benefits for injuries that were not suffered at their workplace. When denying apportionment, the Workers' Compensation Appeals Board (WCAB) should not be entitled to rely on a medical report that fails to apportion, to a previous injury or illness that has been the subject of a prior claim for damages.

SB 714 will ensure that an employee cannot receive more than 100 percent compensation for a particular injury throughout their lifetime.

It places the burden of proof for apportionment of a permanent disability on the defendant and specifies the standard of proof.

Prohibits the appeals board from relying on any medical report that fails to fully address the issue of apportionment.

Provides that if an applicant has received a prior award of permanent disability, it shall be presumed that the prior permanent disability exists at the time of any subsequent injury.

Vocational Rehabilitation

♦ SB 758 (Poochigian)

California is the only state in the nation that mandates vocation rehabilitation. Vocational rehabilitation costs the workers' compensation system a half billion dollars each year, yet the rates of employees returning to work are declining. According to the California Health and Safety and Workers' Compensation Commission,

> "CHSWC research has demonstrated and the workers' compensation community has expressed concern that significant numbers of injured workers in California do not return to work as early as feasible, nor do they return to work with appropriate work restrictions. In 'OSHA Durations Report: Return to Work by State, Industry, Age', recently published by the Work Loss Data Institute, twenty-seven percent of 1999 days-away-from-work cases in California had 31 or more days-away-from-work, the third-worst record in the nation."

SB 758 eliminates the mandatory nature of the vocational rehabilitation program, provides instead that vocational rehabilitation be voluntary. The bill also eliminates the ability to "cash-out" the vocational rehabilitation benefit for $10,000.

Penalties

♦ SB 457(McPherson)—Chamber- & CMTA-Sponsored

The law requires all medical bills be paid within sixty days of receipt. If the claims adjusting agency pays a bill late, under Labor Code Section 5814, a Workers' Compensation Appeals Board (WCAB) Judge may assess a 10 percent penalty against the entire award of medical care, not just the delayed portion. All the medical treatment provided or to be provided in the future is considered in this calculation. So, if at final settlement the entire claim is worth $100,000, the penalty is $10,000. This penalty far exceeds the "crime," which could be a simple clerical error that caused the payment to be mailed late.

The inequity of the system contained in section 5814 cuts both ways. If the total payment of the type of benefit delayed is small, $8700 for temporary disability, then the penalty on a late check for $175 will be $870. If the damage caused by that unreasonable delay was great, the worker lost his housing, for example, the penalty is too slight.

Simply stated, this penalty is obsolete and cannot be administered fairly by the judges as currently written. A long line of Supreme Court cases has repeated call upon the Legislature to remedy these faults. While the most recent legislation, AB 749, amended the penalty section of 5814 to prevent multiple penalties for a single violation, it ignored the inherent inequities of the fine structure.

Here is an example in the case of a severe injury with high medical costs:

- Over $700,000 in medical care has been paid.
- Over seven hundred medical bills were paid on time.
- The total lifetime medical care plan projects an additional five million dollars to be paid during the life of the injured worker.
- If the payment of a single pharmacy bill for $15.58 was delayed for six months, the worker can seek a section 5814 penalty.
- If the judge finds the delay to have been unreasonable, the initial penalty will be $70,000.

- Every subsequent medical fee payment will have an additional 10 percent added to the amount paid for the rest of the life of the injured worker.

- The total potential penalty for the bill is $570,000, treated like any award—divided between the worker and his or her lawyer.

Section 5814 penalties are also assessed, in the same manner, against State agencies. State and local taxes pay for these penalties. The County of Los Angeles recently paid a $1,000,000 section 5814 penalty. When the School Joint Power Authorities and ABAG pays unfair penalties it takes money away from the schools at a time when each dollar means teachers salaries and schoolbooks.

Section 5814 is also obsolete. The comprehensive oversight of the Audit Unit of the Department of Workers' Compensation and the addition of "automatic" penalties under Labor Code section 4650(d), have overshadowed section 5814. The 10 percent penalty is unfair and unworkable. We should no longer accept the arbitrary and unjust swings of this statute and accept the repeated invitation from numerous Supreme Court panels to fix the uneven application of it or repeal it altogether.

SB 457 changes the penalty on the entire amount to a 25 percent penalty for the portion of the award that was unreasonably delayed, or $500, whichever is greater, but the aggregate amount of these penalties shall not exceed $5,000 per claim.

♦ SB 759 (Poochigian)

The costs of litigation are a significant factor in the rising costs of the worker's compensation system. In their report regarding Labor Code section 5814 claims, the California Health and Safety and Workers' Compensation Commission, noted the following:

> "Over the past thirty years, this brief provision has been the subject of considerable litigation and controversy. In 1968, one appellate court observed that the section 'is no model of legislative draftsmanship' and 'many problems are buried in its language when the realities of workmen's compensation litigation are considered.' In 1979, the Supreme Court, faced with the possibility of what it termed 'harsh and unfair results,' adopted 'the more moderate construction of the statutory language' and limited the 10 percent penalty to 'the particular class of benefit delayed or withheld.' This interpretation, in turn, has produced further conflicts and criticism of the statute. In 1998, [California] Supreme Court Justice Baxter stated that the Legislature would 'do well to consider the constitutional implications of the present penalty scheme' and warned that if the Legislature does not act, 'the court might have no alternative but to invalidate the penalty scheme in toto.' It is comments such as these that have led to calls for revision of the present penalty provisions."

SB 759 establishes a 90-day statute of limitations on filing 5814 claims.

Provides that a single violation can be filed only once under Sections 5814, 4650 and 5813.

Miscellaneous

♦ SB 731 (Brulte)

Inmates of a state penal or correctional institution can receive workers' compensation benefits for an injury related to assigned employment while incarcerated.

SB 731 repeals this provision.

♦ SB 176 (Johnson)

Employers complain that they are often not notified of changes in their class codes. Class codes are crucial in determining the premium level and vary widely based upon the type of work each employee does. A reclassification can result in huge premium increases. The situation is made worse when the employer is finds himself liable for a large retroactive premium increase for which he did not anticipate or budget.

SB 176 solves this problem by requiring a rating organization to notify a policyholder immediately if it imposes a change in the classification assignment of the policyholder.

SB 176 requires a rating organization to notify a policyholder if it imposes a change in the classification assignment of the policyholder, and would provide that a rating organization may satisfy this requirement by furnishing the policyholder with a copy of the notice that it provides to the insurer regarding the change in classification assignment.

Garamendi/Davis Proposal

Insurance Commissioner John Garamendi proposed a plan to reform California's "runaway" workers' compensation system, including creation of a new insurance system for injured workers that would merge workers' compensation with group health insurance plans. Commissioner Garamendi announced a seven-part plan that he devised with the help of two task forces that convened in January. The press release gave scant details about this plan. Garamendi’s plan aligns himself solidly with universal health-care advocates in the Legislature and the commissioner also threw a bone to employers by hinting at sympathy toward their plan to overhaul the disability rating system.

Garamendi said the state should immediately focus on these areas:

- Improved financial oversight
- Medical cost containment
- Consistency in determining the level of permanent disability
- Improved coordination and communication with state regulatory agencies
- Continued aggressive fraud interdiction
- Creation of a 24-hour medical care system merging health insurance with workers' compensation medical care

The lynchpin of the Commissioner's plan is the merging of traditional health insurance with workers' compensation medical care system. But this plan is expected to combine some element of universal health care. The most likely combination would include the "pay or play" provision of Senator Burton's plan. Under this scenario an employer would have to provide health care coverage at a government-determined level or pay a new tax for the provision of government-sponsored health care.

Immediately after Legislative Republicans called on the Governor to call a special session to deal with the workers' compensation crisis, the Governor announced plans for a Workers' Compensation reform package. Details of the plan are unknown, but it is likely his plan will mirror the Insurance Commissioner's Plan.